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STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

March 26, 2015

Members of the Senate Committee on Health and Welfare
Members of the House Committee on Healthcare
Members of the House Committee on Human Services

Dear Colleagues,

Through fiscal year 2014, $675 million of combined state and federal funding has been spent as MCO Investments. A recent report by the Agency of Human Services (AHS) regarding MCO Investments[1] highlights that performance measurement to monitor the effectiveness of the investments has not been robust for all investments. This report influenced my office's decision to delay an audit of whether MCO Investments have achieved measurable positive results consistent with intended purposes.[2] Because of the significance of the AHS report subject matter and our decision to postpone an audit, I am bringing the findings and recommendations of the AHS report to your attention. I also explain the rationale for postponing an audit.

AHS report findings

The AHS report[3] resulted from an internal review conducted at the behest of the Secretary of AHS. Among other items, the review was expected to determine if existing AHS MCO investment[4] expenditures realized optimal outcomes, including whether appropriate measures were in place and the investments had performed to expectations.

Based on the findings and conclusion in the report, it appears the internal review team was able to assess whether appropriate measures were in place for the 36 MCO Investments reviewed. However, the team's assessment of whether the MCO investments performed to expectations was limited to less than half (15 of 36) due to departments' failure to track actual results. My office has summarized AHS's findings, but we have not independently verified the data in the report.

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[1] MCO investments are a component of the State's Medicaid Waiver, the Global Commitment to Health. See Attachment 1 for an overview.

[2] The purposes are outlined in the State's Medicaid Waiver (See Attachment 1). AHS uses the purposes as criteria to determine whether a program qualifies as an MCO Investment. The scope of our planned audit does not include reviewing AHS's original determination that an investment qualified under one of the four criteria, rather whether it had the intended effect.

[3] See Attachment 2 for the report.

[4] The scope of the review covered AHS department MCO Investments greater than $500,000. This resulted in the review of 36 of the 87 FY2014 MCO Investments

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The internal review team concluded that most of the MCO Investments had performance measures, but noted significant shortcomings with regard to establishing targets and tracking actual results.
Specifically,

- Performance measures existed for 80 percent (29 of 36) of the investments.
- Measures were complete and well developed for 56 percent (20 of 36) of investments.
- Targets were established for 33 percent of the objectives associated with MCO Investments.
- Actual results were tracked for 44 percent of investments (16 of 36).
- Performance improved for 93 percent of the 15 investments for which actual results were tracked for 2 or more points in time.

The Vermont Department of Health had targets for about 82 percent of the objectives for its MCO Investments and tracked results for about 90 percent of its performance measures. The Department of Aging and Independent Living had no targets and did not track actual results. The Department of Corrections and Department of Children and Families had no targets, but did some tracking of results.

Targets are essential to performance measurement and improvement. Without targets, it is not possible to assess whether expected results were achieved. Additionally, the failure to track actual results for performance measures prevents an assessment of whether progress has been made towards achieving goals and objectives.

AHS report recommendations

The internal review recommendations included the following:

1) As Phase II of the internal review, collect data for MCO Investments where no data was available to review.
2) Departments should develop appropriate performance measures for all MCO Investments.
3) MCO Investment application should be updated to include SMART[5] objectives, performance measures, and a plan for monitoring performance.
4) AHS Performance Accountability Committee or other existing performance accountability work groups or committees should be utilized to develop a checklist to support development of performance targets and benchmarks and to develop agency wide investment performance measure criteria or a performance measure development tool.
5) AHS may need to coordinate and/or integrate data analysis functions agency-wide. Further, the agency needs to continue to develop an effective performance monitoring and evaluation system, including the development and implementation of agency-wide standards, tools for measuring and monitoring, and training on performance accountability principles.

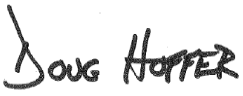
[5] SMART stands for Specific, Measurable, Achievable, Realistic, and Time-bound activities.

SAO decision to delay audit

My office decided not to conduct an audit at this time because the AHS internal review disclosed significant issues that would prevent us from assessing whether MCO Investments had achieved the purposes outlined in the State's Medicaid waiver. We believe it would be more appropriate to conduct an audit once AHS has had a chance to implement the corrective actions recommended in the report and remediate these issues.

A timeline for correction was not specified in the report. However, we will obtain an update of the Agency's progress at some point in the next fiscal year.

Best regards,



Doug Hoffer
Vermont State Auditor

ATTACHMENT 1

MCO Investments – Overview

Under Vermont's current Global Commitment (GC) demonstration waiver, Medicaid services are provided by a Managed Care Entity (MCE) that is – uniquely to Vermont – operated by state government. The Department of Vermont Health Access (DVHA) is the MCE for Vermont Medicaid.

The GC waiver provides the state of Vermont with expenditure authority to invest in health related services and activities, and draw federal receipts, for costs that would not otherwise be Medicaid matchable. These initiatives are known as "MCO Investments."

The GC waiver requires that MCO Investments address one of the following purposes:

1. Reduce the rate of uninsured and/or underinsured in Vermont;
2. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
3. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
4. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Up to the end of fiscal year 2014, $675 million of combined state and federal funding has been spent as MCO Investments. For some of the programs, MCO Investment is not the sole source of funds. MCO Investments administered by entities other than DVHA are governed by a Memorandum of Understanding or Intragovernmental Agreement with DVHA.

See Table 1 for MCO Investment spending by entity for FY 2014. Figure 1 illustrates the proportion of MCO Investments by purpose and value. Figure 2 shows the proportion of MCO Investments by purpose and number of investments.

ATTACHMENT 1

Table 1: MCO Investment FY2014 Expenditures by State Organization

Department/Entity	Number of MCO Investments	SFY14 Actual Expenditure
Department of Mental Health	11	39,043,497
Department for Children & Families	17	17,885,475
Department of Health	25	16,576,934
Department of Vermont Health Access	8	15,879,646
Agency of Education	1	10,454,116
AHS Central Office	2	7,683,876
Department of Disabilities, Aging and Independent Living	8	6,832,417
Department of Corrections	9	5,308,263
University of Vermont	1	4,006,156
Green Mountain Care Board	1	2,360,462
Vermont Veterans' Home	1	410,986
Vermont State Colleges	1	405,407
Department of Financial Regulation	1	165,946
Agency of Agriculture, Food & Markets	1	90,278
Total	**87**	**$127,103,459**

ATTACHMENT 1

Figure 1: Proportion of MCO Investments by Purpose and Value

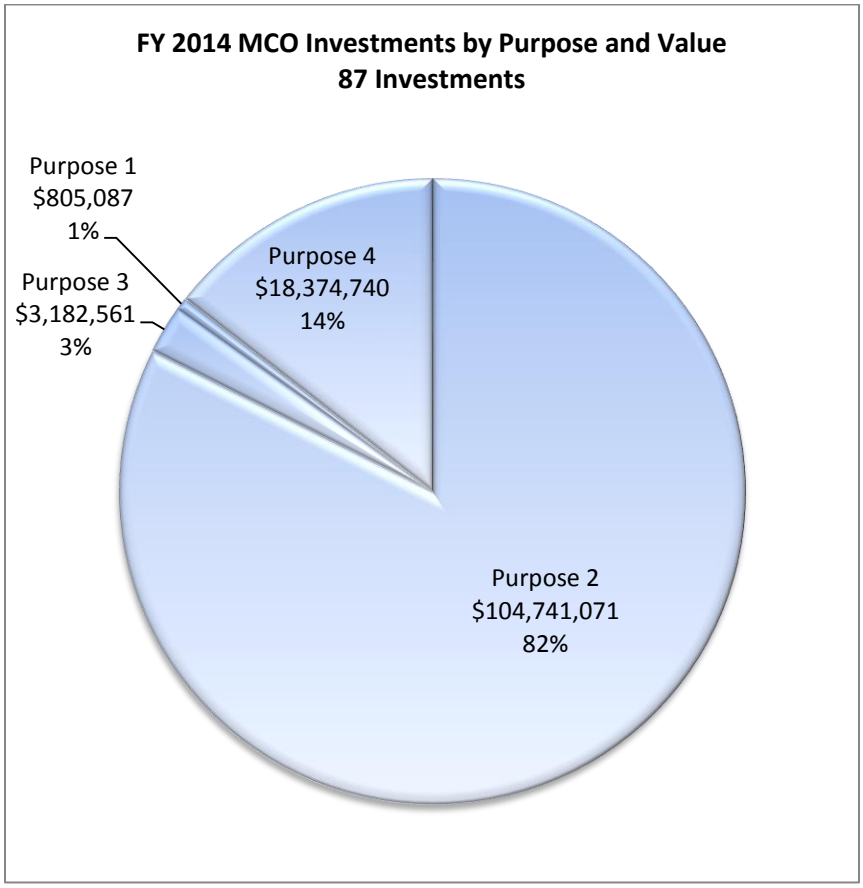
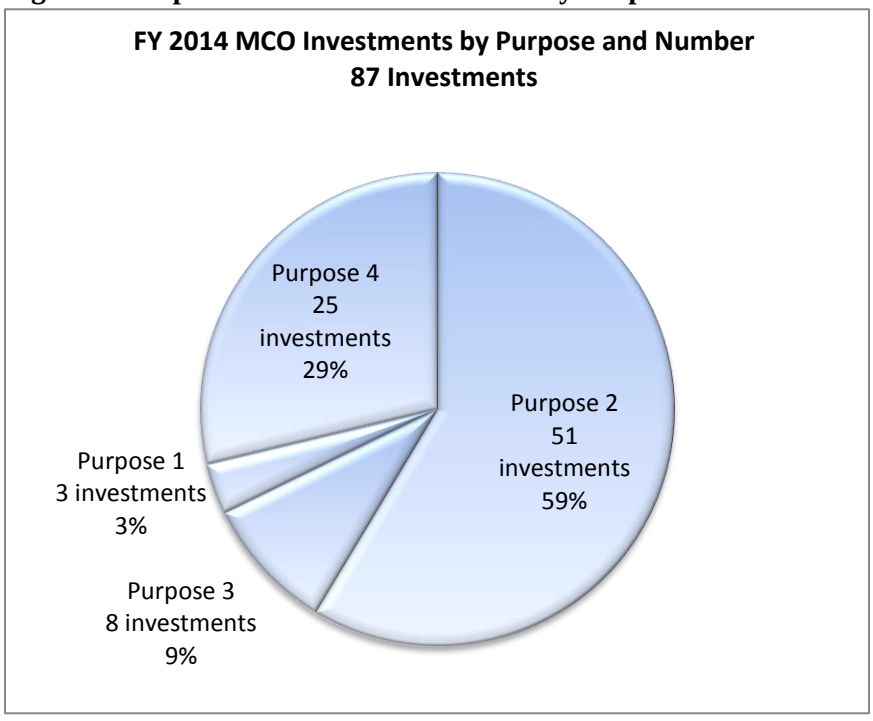


Figure 2: Proportion of MCO Investments by Purpose and Number



Global Commitment MCO Investment Review
Summary Report: Investments > $500,000

I. Introduction

The GC demonstration provides the state of Vermont with expenditure authority to invest in health related services and activities, and draw federal receipts, for costs that would not otherwise be Medicaid matchable. These initiatives are known as "MCO Investments". In June, 2014, Secretary Doug Racine tasked AHS Commissioners with undergoing a comprehensive review of their existing MCO Investments in support of AHS' increased focus on demonstrating outcomes and utilizing performance management methods and tools such as Results Based Accountability (RBA) in preparation for the SFY16 budget development process. Moving beyond measuring and reporting data, to managing performance toward improving results, is an AHS-wide priority and was one of the drivers to initiate this review.

Beginning in September of 2014, a team of individuals assembled by AHS and DVHA began a review process of the Global Commitment to Health investment programs. The team comprised individuals with clinical, quality, compliance and financial expertise and significant experience with MCO programs.

The review is expected to answer the following questions:

- Are existing AHS MCO Investment expenditures realizing optimal outcomes – are appropriate performance measures in place and is the service performing to expectations?
- Can existing MCO Investment appropriations be realigned to better meet one of the four allowable criteria?
- Are there any existing MCO Investments that could become programmatic or administrative claims instead? PHPG has done some initial analysis and this review should build off of that work.

II. Methods

The Investment Review Team was made up of the following individuals:

- Bill Clark, DVHA
- Cindy Thomas, DVHA
- Erin Carmichael, DVHA
- Scott Strenio, DVHA
- Connie Harrison, DVHA
- Shawn Skaflestad, AHSCO

One of the first tasks of the group was to review all historical documents associated with GC Investments. This included reviewing original applications (when available), investment detail sheets, financial information, as well as any supporting documents. If an Investment exists without an original application, the Investment Review Team worked collaboratively with the appropriate department to better understand the history and program definitions associated with each existing MCO Investment. In addition, the group reviewed the initial investment analysis that was completed by PHPG in December, 2013. After their preliminary work was completed, the team developed a review tool designed to guide the collection of data about each investment. Team members conducted the first review as a group in order to ensure a consistent approach to subsequent reviews. Based on feedback, the tool was modified before data collection began. The team decided to prioritize a review of AHS Department investments greater than

$500,000 (N=40); this review has become Phase I of what will be an ongoing review/improvement cycle. Each team member was assigned a Department and initiated data collection phase of the project. Reviews included interviews with program and business office staff and evaluation of other program data through documents and web sites provided by program staff. The data from each review was collected into a single excel spreadsheet. The review team was asked to be as objective as possible in their data collection. As a final step, the group is expected to analyze the aggregate data and generate a MCO Investment Summary (as-is status) Report that includes recommendations for potential improvements to AHS Commissioners.

III. Findings

A: **All AHS Department* Investments – SFY14 Actuals**

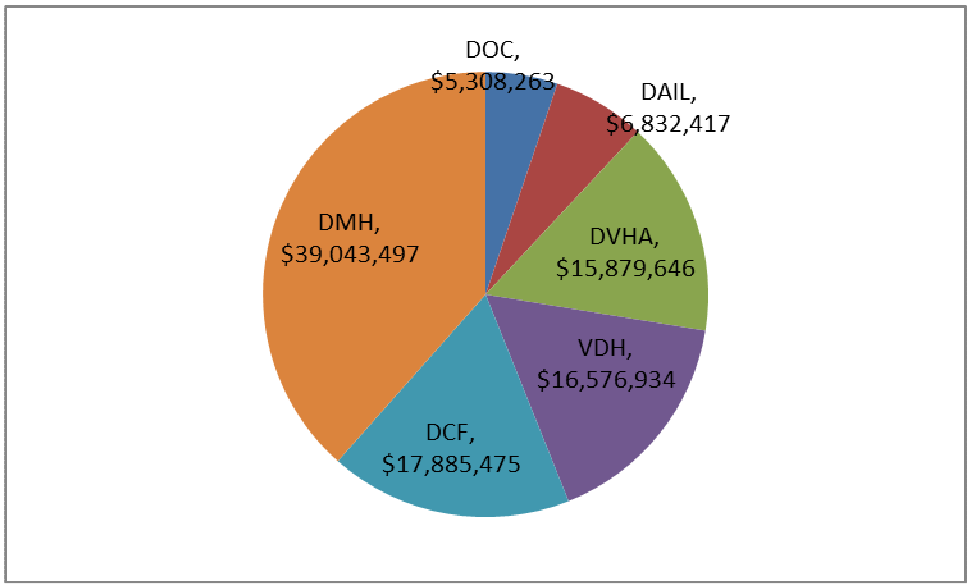
Total Number: 78 Total Amounts: $101,526,232

Table 1: MCO Investments by AHS Department (see Appendix B for detail)

Department	Number	Amount
DOC	9	$5,308,263
DAIL	8	$6,832,417
DVHA	8	$15,879,646
VDH	25	$16,576,934
DCF	17	$17,885,475
DMH	11	$39,043,497
TOTAL	78	$101,526,232

scope excludes all non-AHS department expenditures.

Figure 1: MCO Investments by AHS Department



Range: $3,375 (VDH) - $11,331,235 (DMH)

Average: $1,301,618

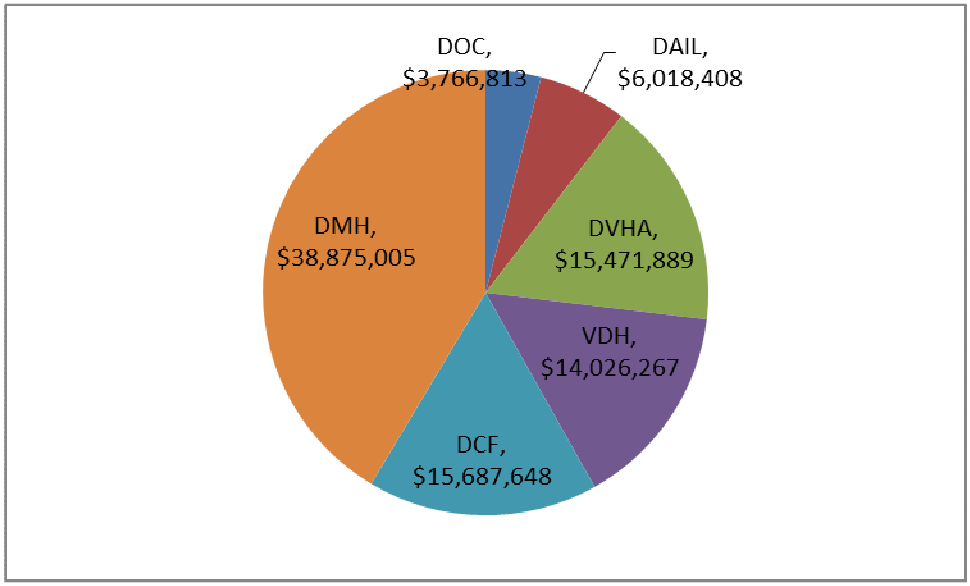
B: **AHS Department Investments Greater Than $500,000**

Total Number: 40 Total Amounts: $93,846,030

Table 2: MCO Investments Greater than $500,000 by AHS Department (see Appendix C for detail)

Department	Number	Amount
DOC	3	$3,766,813
DAIL	4	$6,018,408
DVHA	5	$15,471,889
VDH	13	$14,026,267
DCF	5	$15,687,648
DMH	10	$38,875,005
TOTAL	40	$93,846,030

Figure 2: MCO Investments Greater than $500,000 by AHS Department



Range: $543,196 (DCF) - $11,331,235 (DMH)

Average: $2,346,151

1. *Investment Goals*

CMS has approved four broad categories of expenditure as allowable under the demonstration. Final category assignment and approval for all investments is at the state's sole discretion. As per the 2013 STCs demonstration funds may be used for the following purposes:

a. Reduce the rate of uninsured and/or underinsured in Vermont;

b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Table 3 below shows 40 AHS MCO Department Investments > $500,000 by Goal.

Table 3: MCO Investments by Goal

Criteria	Number	Amount
a	1	$760,819
b	24	$77,647,170
c	4	$ 2,867,597
d	11	$12,570,444
TOTAL	40	$93,846,030

Four MCO Investments were excluded from review as they no longer exist post-SFY14; N=36 for the performance metrics review.

2: *Investment Objectives*

Objectives describe the desired programmatic outcomes of the activities being funded. Objectives also describe the expected results of the activities and establish the foundation for assessment. The group examined the rigor of the objectives associated with each of the investments. One way to develop well-written objectives is to use the SMART approach. Developing specific, measurable, achievable, realistic, and time-bound objectives requires orderly thinking and a clear picture of the results expected from program activities. The more specific your objectives are, the easier it is to demonstrate success. Once way to ensure that your objective is measureable is to use performance targets. A target is the desired level of performance you want to see that represents success at achieving your objective. Targets are essential to performance measurement and improvement. While the group did not review the objectives against all SMART criteria – they did assess investments re: their use of targets. The following tables show the percent of investment objectives that use targets when assessing their performance.

Table 4: Targets – Total

TARGETS	PERCENT
Yes	33.3
No	67.7
TOTAL	100.0

Table 5: Targets – by Department

DEPARTMENT	TARGETS		
	YES	NO	TOTAL
DAIL	0.0	100.0	100.0
DCF	0.0	100.0	100.0
DMH	20.0	80.0	100.0
DOC	0.0	100.0	100.0
DVHA	33.3	67.7	100.0
VDH	81.8	18.2	100.0

Benchmarks are points of reference that can be used to gauge how well—or how poorly—an investment is performing. Benchmarking is the process that is used to assess an investments performance against high performing programs (best practice or standards) with similar goals and objectives. Investment benchmarks can either be internal (within Department) or external (outside of Department). The following tables show the percent of investments that included benchmarks when assessing their performance.

Table 6: Use of Benchmarks – Total

BENCHMARKS	PERCENT
Yes	13.9
No	30.6
N/A	55.5
TOTAL	100.0

Table 7: Use of Benchmarks– by Department

DEPARTMENT	BENCHMARK USE			
	YES	NO	N/A	TOTAL
DAIL	0.0	25.0	75.0	100.0
DCF	0/0	80.0	20.0	100.0
DMH	30.0	20.0	50.0	100.0
DOC	0.0	0.0	100.0	100.0
DVHA	0.0	33.3	67.7	100.0
VDH	18.2	27.3	54.5	100.0

3: *Investment Performance Measures*

Performance measures help departments demonstrate progress towards achieving investment goals and objectives. The group assessed the presence of performance measures associated with investments. The following tables show the percent of investments with performance measures.

Table 8: Performance Measures – Total

PM	PERCENT
Yes	80.6
No	19.4
TOTAL	100.0

Table 9: Performance Measures – by Department

DEPARTMENT	PERFORMANCE MEASURE		
	YES	NO	TOTAL
DAIL	25.0	75.5	100.0
DCF	100.00	0.0	100.0
DMH	70.0	30.0	100.0
DOC	67.7	33.3	100.0
DVHA	100.0	0.0	100.0
VDH	100.0	0.0	100.0

In addition – the reviewers were asked to comment on the quality of the investment performance measures. While subjective in nature – the results are useful. The percent of investments with performance measures that address an aspect of performance that the program can significantly influence or does the funding support activities that directly influence the measures identified can be found in the following tables.

Table 10: Performance Measure Quality – Total

QUALITY PM	PERCENT
Yes	66.7
No	0.0
N/A	33.3
TOTAL	100.0

Table 11: Performance Measure Quality – by Department

DEPARTMENT	QUALITY PM			
	YES	NO	N/A	TOTAL
DAIL	25.0	0.0	75.0	100.0
DCF	100.00	0.0	0.0	100.0
DMH	60.0	0.0	40.0	100.0
DOC	0.0	0.0	100.0	100.0
DVHA	33.3	0.0	67.7	100.0
VDH	100.0	0.0	0.0	100.0

In addition – the reviewers were asked to comment on whether or not they felt that the performance measures were complete and well developed. The percent of investments with complete and well developed performance measures can be found in the following tables.

Table 12: Number and percent that have complete and well developed performance measures – Total

WELL DEVELOPED PM	PERCENT
Yes	55.6
No	44.4
TOTAL	100.0

Table 13: Number and percent that have complete and well developed performance measures – by Department

DEPARTMENT	WELL DEVELOPED PM		
	YES	NO	TOTAL
DAIL	0.0	100.0	100.0
DCF	100.0	0.0	100.0
DMH	10.0	90.0	100.0
DOC	67.7	33.3	100.0
DVHA	33.3	67.7	100.0
VDH	100.0	0.0	100.0

4: *Investment Results*

Good performance measures should be calculated using valid and reliable data available on a timely basis. The following tables show the percent of investments that had data to support performance measure development (N=16).

Table 14: Performance Measure Results – Total

PM RESULTS	PERCENT
Yes	44.4
No	27.8
N/A	27.8
TOTAL	100.0

Table 15: Performance Measure Results – by Department

DEPARTMENT	PM RESULTS			
	YES	NO	N/A	TOTAL
DAIL	0.0	25.0	75.0	100.0
DCF	40.0	60.0	0.0	100.0
DMH	10.0	50.0	40.0	100.0
DOC	67.7	0.0	33.3	100.0
DVHA	33.3	0.0	67.7	100.0
VDH	90.9	9.1	0.0	100.0

In order to track and trend investment performance over time – data for more than two points in time is necessary. The following tables show the percent of investments with data (N=16) – that had results for more than two points in time (N=15).

Table 16: Performance Measure Results for 2 or More Points in Time – Total

PM DATA X2	PERCENT
Yes	93.8
No	6.2
TOTAL	100,0

Table 17: Performance Measure Results for 2 or More Points in Time – by Department

DEPARTMENT	PM DATA X2		
	YES	NO	TOTAL
DCF	50.0	50.0	100.0
DMH	100.0	0.0	100.0
DOC	100.0	0.0	100.0
DVHA	100.0	0.0	100.0
VDH	100.0	0.0	100.0

In an attempt to determine the performance of the investment – reviewers were asked to characterize the overall performance of the investment over time. The following tables show the percent of investments with data for two or more points in time (N=15) whose performance got better, remained the same, or decreased over time.

Table 18: Investment Performance Over Time – Total

PERFORMANCE	PERCENT
GOT BETTER	93.3
DECREASED	0.0
REMAINED THE SAME	6.7
TOTAL	100.0

Table 19: Investment Performance Over Time – by Department

DEPARTMENT	PERFORMANCE				
	GOT BETTER	SAME	DECLINED	N/A	TOTAL
DCF	100.0	0.0	0.0	0.0	100.0
DMH	100.0	0.0	0.0	0.0	100.0
DVHA	100.0	0.0	0.0	0.0	100.0
VDH	90.0	0.0	0.0	10.0	100.0

5: *Investment – Other*

A final purpose of the review is to determine if any of the programs now supported through investments could be considered as part of the Medicaid Managed Care PMPM rate setting. During its review, the group considered overall program goals, services and provider networks associated with a given department to determine if employing a revised approach to reimbursement models or rate setting would decrease reliance on MCO investment categories. PHPG completed a partial review of MCO investments that was used as a reference during this process. The following tables identify the percent of investments that had findings that supported PHPG recommendations.

Table 20: Support for PHPG Recommendations– Total

SUPPORT	PERCENT
Yes	41.7
No	0.0
N/A	58.3
TOTAL	100.0

Table 21: Support for PHPG Recommendations– by Department

DEPARTMENT	PERCENT SUPPORT			
	YES	NO	N/A	TOTAL
DAIL	40.0	0.0	60.0	100.0
DCF	0.0	0.0	100.0	100.0
DMH	80.0	0.0	20.0	100.0
DOC	67.7	0.0	33.3	100.0
DVHA	0.0	0.0	100.0	100.0
VDH	27.3	0.0	72.7	100.0

A table of the investments that support PHPG recommendations is included in Appendix A of this report.

IV. Conclusions & Recommendations:

Conclusions

The overall purpose of this review was to determine the status of MCO investments. To accomplish this goal – it was necessary to determine the important elements of performance management. The review team was made up of DVHA and AHSCO staff familiar with quality assessment and performance improvement methodologies and tools. The group developed a data collection tool which included all the important elements. The following section reports the conclusions and recommendations that resulted from their work.

Developing specific, measurable, achievable, realistic, and time-bound objectives requires orderly thinking and a clear picture of the results expected from program activities. A key element of a SMART objective is the use of a performance target and the use of benchmarks. According to the data collected, approximately one third of objectives associated with investments contained performance targets. While a majority of AHS Departments used performance targets while writing their investments – only VDH used them a majority of the time. Benchmarking can be another way to gauge how well—or how poorly—an investment is performing. Despite the benefits– less than fifteen percent of the investments included some sort of benchmarking when assessing their investments performance. All AHS Departments were equally challenged with respect to the use of benchmarks. Without well-written objectives – assessing investment performance and developing improvement activities is a challenge.

Performance measures help demonstrate progress towards achieving goals and objectives. Over eighty percent of investments had performance measures. All Departments except DAIL identified performance measures for their investments. Overall, the quality of the performance measures being used is adequate. Approximately two thirds of the existing performance measures were determined to be of good quality.

Good performance measures should be calculated using valid and reliable data available on a timely basis. Less than half of the Departments provided results for their performance measures. There appears to be some disparity among the Departments re: the availability of data or staff necessary to produce performance measure rates. VDH provided results approximately ninety percent of the time – while DAIL and DMH provided rates at much lower frequency (zero and ten percent respectively). Over ninety percent of those investments that had rates available at the time of review – were able to provide it for two or more points in time.

For those investments that had rates available for two or more points in time – reviewers were asked to characterize the overall performance of the investment over time. Of the fifteen investments that met this criterion – the performance for the overwhelming majority of them was characterized by reviewers as getting better over time. The performance of one investment was characterized as remaining the same – and the performance of zero investments was characterized as declining.

Prior to this review, PHPG completed a partial review of MCO investments to determine which investments might be considered as part of the Medicaid Managed Care PMPM rate setting. During its review, the group found evidence to support PHPG's recommendations for approximately forty percent of the Department investments greater than $500,000. The highest percentage of agreement was found in DAIL, DMH, and DOC.

Recommendations

Departments need to develop SMART objectives for all investments. This includes the use of performance targets and benchmarks. Rather than doing this work independently, it might make sense for the AHSCO to play a role in coordinating this work with accountability folks across the agency. Any new work should consider existing workgroups and committees. For example, the AHS Performance Accountability Committee (PAC) is an existing group that could be tapped to develop a SMART Objective checklist to support this work.

Also, departments should develop appropriate Performance Measures for all investments. While the majority of investments had performance measures identified – there is variation among the departments re: their quality. Similar to the recommendation above, there might be some utility in having existing accountability work groups or committees develop agency-wide investment performance measure criteria or perhaps a performance measure development tool.

Phase II of this review should begin with collecting data for those investments where no data was made available to review. Given the lack of rates for identified performance measures and the potential disparity of data among departments– Departments need to determine the root cause for the lack of data to support the identified investment performance measures. If resource issues are identified as a root cause - AHSCO needs to consider alternative models to data analysis and governance. Perhaps AHS needs to coordinate and/or integrating data analysis functions agency-wide. Phase II of the review should be completed by October 1, 2015.

Departments need to review their investments – with an eye towards converting them towards Medicaid billable administration or services when feasible. Priority should be given to those investments identified by both PHPG and the review team as having the highest provability of being converted. Appendix A contains a list of priority investments for consideration. AHS Leadership needs to determine the best way to go about this work. DVHA and AHSCO could assist in this process.

Future MCO investment applications should be updated to include the presence of SMART objectives, performance measures, and a plan for monitoring the performance of the investment. MCO investment review team should consider the use of SMART objective criteria and a performance measure checklist. Applying these tools should enhance the ability of AHS Departments to assess the performance of the investment over time.

Finally, many of the aforementioned recommendations point to the need for AHS to continue to develop an effective performance monitoring and evaluation system. As a result, it will be important to tie these recommendations into the broader performance accountability efforts being initiated across the agency.

This includes the establishment of an AHS Performance Accountability Committee (PAC), the development of an AHS Performance Framework that includes the development and implementation of agency-wide standards and tools for measuring, monitoring, improving, communicating, and teaching performance accountability principles, as well as the development of a common language for accountability.

Appendix A

Table 1: Department, Name, and Dollar Amount of Investments for Potential Conversion – based on SFY14 actual expenses

DEPARTMENT	NAME	DOLLAR AMOUNT
DAIL (2)	DS Special Payments for Medical Services	$1,277,148
	Flexible Family/Respite Funding	$2,868,218
Sub Total		**$4,145,366.00**
DMH (7)	Emergency MH for Children & Adults	$6,662,850
	MH Consumer Support programs	$2,178,825
	Respite Services for Youth with SED and their Families	$749,943
	Recovery Housing	$985,098
	MH Outpatient Services for Adults	$2,661,510
	Acute Psychiatric Inpatient Services	$3,011,307
	Mental Health CRT Community Support Services*	$11,331,235
Sub Total		**$27,580,768.00**
DOC (2)	Pathways to Housing	$830,936
	Northeast Kingdom Community Action	$287,662
Sub Total		**$1,118,598.00**
VDH (3)	Family Planning	$1,556,025
	CHIP Vaccines	$707,788
	Recovery Centers	$1,009,176
Sub Total		**$3,272,989.00**
TOTAL	14	**$36,117,721**

*Work has been underway throughout SFY15 to move certain claimable CRT costs from Investment to Program.

Appendix B

Table 1: Department, Name, and Dollar Amount of All AHS Department Investments – based on SFY14 actual expenses:

DEPARTMENT	NAME	DOLLAR AMOUNT
DAIL (8)	Quality Review of Home Health Agencies	$51,697
	Self-Neglect Initiative	$200,000
	Mobility Training/Other Svcs.-Elderly Visually Impaired	$245,000
	HomeSharing	$317,312
	Seriously Functionally Impaired: DAIL	$859,371
	Support and Services at Home (SASH)	$1,013,671
	DS Special Payments for Medical Services	$1,277,148
	Flexible Family/Respite Funding	$2,868,218
Sub Total		**$6,832,417.00**
DCF (17)	GA Community Action	$25,180
	Medical Services	$33,514
	Prevent Child Abuse Vermont: Nurturing Parent	$54,231
	Aid to the Aged, Blind and Disabled Res Care Level III	$89,159
	Prevent Child Abuse Vermont: Shaken Baby	$111,094
	Aid to the Aged, Blind and Disabled Res Care Level IV	$183,025
	Children's Integrated Services Early Intervention	$200,484
	Challenges for Change: DCF	$207,286
	Lund Home	$237,387
	GA Medical Expenses	$253,939
	Strengthening Families	$399,841
	Lamoille Valley Community Justice Project	$402,685
	Therapeutic Child Care	$543,196
	Building Bright Futures	$594,070
	Essential Person Program	$801,658
	Aid to the Aged, Blind and Disabled CCL Level III	$2,611,499
	Residential Care for Youth/Substitute Care	$11,137,225
Sub Total		**$17,885,475.00**
DMH (11)	Emergency MH for Children & Adults	$6,662,850
	MH Consumer Support programs	$2,178,825
	Respite Services for Youth with SED and their Families	$749,943
	Recovery Housing	$985,098
	MH Outpatient Services for Adults	$2,661,510
	Acute Psychiatric Inpatient Services	$3,011,307
	Institution for Mental Disease Services: DMH	$7,194,964
	Mental Health CRT Community Support Services*	$11,331,235
	Special Payments for Treatment Plan Services	$168,492
	Seriously Functionally Impaired: DMH	$721,727
	Mental Health Children's Community Services	$3,377,546
Sub Total		**$39,043,497.00**
DOC (9)	Pathways to Housing	$830,936
	Northeast Kingdom Community Action	$287,662

	Intensive Sexual Abuse Program	$19,322
	Intensive Domestic Violence Program	$64,970
	Northern Lights	$335,587
	Return House	$399,999
	Challenges for Change: DOC	$433,910
	Intensive Substance Abuse Program (ISAP)	$547,550
	Community Rehabilitative Care	$2,388,327
Sub Total		**$5,308,263.00**
DVHA (8)	Buy-In	$17,728
	HIV Drug Coverage	$26,540
	Patient Safety Net Services	$363,489
	Vermont Information Technology Leaders/HIT/HIE/HCR	$1,549,214
	Vermont Blueprint for Health	$2,490,206
	Institution for Mental Disease Services: DVHA	$6,948,129
	Civil Union	$760,819
	Family Supports	$3,723,521
Sub Total		**$15,879,646.00**
VDH (25)	Family Planning	$1,556,025
	CHIP Vaccines	$707,788
	Recovery Centers	$1,009,176
	Renal Disease	$3,375
	Patient Safety - Adverse Events	$38,731
	Fluoride Treatment	$59,362
	TB Medical Services	$59,872
	Poison Control	$152,433
	FQHC Lookalike	$160,200
	Immunization	$165,770
	Challenges for Change: VDH	$288,691
	WIC Coverage	$317,775
	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$326,184
	Healthy Homes and Lead Poisoning Prevention Program	$479,936
	Emergency Medical Services	$498,338
	Area Health Education Centers (AHEC)	$547,500
	Epidemiology	$623,363
	Tobacco Cessation: Community Coalitions	$632,848
	Vermont Blueprint for Health	$713,216
	Physician/Dentist Loan Repayment Program	$1,040,000
	Statewide Tobacco Cessation	$1,073,244
	Substance Abuse Treatment	$2,363,671
	Health Laboratory	$2,494,516
	Health Research and Statistics	$576,920
	Community Clinics	$688,000
Sub Total		**$16,576,934.00**
TOTAL	78	**$101,526,232.00**

Appendix C

Table 1: Department, Name, and Dollar Amount of All AHS Department Investments > $500,000 – based on SFY14 actual expenses

DEPARTMENT	NAME	DOLLAR AMOUNT
DAIL (4)	Seriously Functionally Impaired: DAIL	$859,371
	Support and Services at Home (SASH)	$1,013,671
	DS Special Payments for Medical Services	$1,277,148
	Flexible Family/Respite Funding	$2,868,218
Sub Total		**$6,018,408.00**
DCF (5)	Therapeutic Child Care	$543,196
	Building Bright Futures	$594,070
	Essential Person Program	$801,658
	Aid to the Aged, Blind and Disabled CCL Level III	$2,611,499
	Residential Care for Youth/Substitute Care	$11,137,225
Sub Total		**$15,687,648.00**
DMH (10)	Emergency MH for Children & Adults	$6,662,850
	MH Consumer Support programs	$2,178,825
	Respite Services for Youth with SED and their Families	$749,943
	Recovery Housing	$985,098
	MH Outpatient Services for Adults	$2,661,510
	Acute Psychiatric Inpatient Services	$3,011,307
	Institution for Mental Disease Services: DMH	$7194964
	Mental Health CRT Community Support Services	$11,331,235
	Seriously Functionally Impaired: DMH	$721,727
	Mental Health Children's Community Services	$3,377,546
Sub Total		**$38,875,005.00**
DOC (3)	Pathways to Housing	$830,936
	Intensive Substance Abuse Program (ISAP)	$547,550
	Community Rehabilitative Care	$2,388,327
Sub Total		**$3,766,813.00**
DVHA (5)	Vermont Information Technology Leaders/HIT/HIE/HCR	$1,549,214
	Vermont Blueprint for Health	$2,490,206
	Institution for Mental Disease Services: DVHA	$6,948,129
	Civil Union	$760,819
	Family Supports	$3,723,521
Sub Total		**$15,471,889.00**
VDH (13)	Family Planning	$1,556,025
	CHIP Vaccines	$707,788
	Recovery Centers	$1,009,176
	Area Health Education Centers (AHEC)	$547,500

	Epidemiology	$623,363
	Tobacco Cessation: Community Coalitions	$632,848
	Vermont Blueprint for Health	$713,216
	Physician/Dentist Loan Repayment Program	$1,040,000
	Statewide Tobacco Cessation	$1,073,244
	Substance Abuse Treatment	$2,363,671
	Health Laboratory	$2,494,516
	Health Research & Statistics	$576,920
	Community Clinics	$688,000
Sub Total		**$14,026,267.00**
TOTAL	40	**$93,846,030.00**